What triggers requests for ethics consultations?

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ABSTRACT ● **Objective** To investigate what triggers clinicians' requests for ethics consultations. ● **Design** Cross-sectional telephone survey. ● **Setting and participants** Randomly selected physicians throughout the United States who practice in internal medicine, oncology, and critical care. ● **Main measurements** Sociodemographic characteristics, training in medicine and ethics, and practice characteristics; types of ethical problems that prompt requests for consultation, and factors triggering consultation requests. ● **Results** Of 344 responding physicians, 190 (55.2%) reported requesting ethics consultations. Most commonly these were for ethical dilemmas related to end-of-life decision making, patient autonomy issues, and conflict. The most common triggers that led to consultation requests were wanting help resolving a conflict; wanting assistance with interactions with a difficult family, patient, or surrogate; wanting help with making a decision or planning care; and emotional triggers. Physicians who were ethnically in the minority, practiced in communities under 500,000 population, or who were trained in the United States were more likely to request consultations to resolve conflict. ● **Conclusions** Conflicts and other emotionally charged concerns more commonly trigger consultation requests than other cognitively based concerns. When consulting, ethicists need to be prepared to mediate conflicts and handle sometimes difficult emotional situations. The data suggest that ethics consultants might serve clinicians well by consulting on a more proactive basis to avoid conflicts and by educating clinicians to develop mediation skills.

Increasingly, health care facilities are establishing ethics consultation services composed of experts who apply ethical reasoning to dilemmas encountered in medical practice.[1] Yet, despite the breadth and complexity of ethical dilemmas in medicine, clinicians have been slow to use these specialized services.

One reason for this may be that an ethical quandary as such does not prompt requests for a consultation. We hypothesize that consultation requests are usually triggered by concrete factors, such as the need to handle a difficult situation or resolve a conflict, rather than by a desire to use or apply ethical reasoning. An awareness of the factors that are associated with requests for consultations will enable consultants to address the ethical problems faced by clinicians more effectively and will facilitate the integration of consultation services into the clinical setting.

We report a subanalysis of a survey of internists in the United States to determine the factors that trigger requests for ethics consultations.

METHODS

Study population

A national sample of 600 internists was randomly selected from the American Medical Association Master List of Physicians and Medical Students. We randomly sampled 200 cases from each of critical care and pulmonary critical care medicine (n=2,334); medical oncology and hematology-oncology (n=6,536); and internists, not otherwise specified (n=95,885). This selection strategy captured physicians who serve patients with life-threatening illnesses and those who serve more general patient populations. Following randomization, physicians were deemed ineligible for this study only if they reported that they had not been in practice for a year or if they spent less than 20% of their time in direct patient care. Those physicians who acknowledged ever requesting an ethics consultation make up the sample reported here. Results regarding those physicians who did not request a consultation will be reported elsewhere.

Questionnaire

Telephone interviews were conducted between October 1999 and March 2000 by trained interviewers from the Center for Survey Research at the University of Massachusetts, Boston. The interviews took an average of 26 minutes to complete and included both closed and open-ended items.

The questionnaire used during the telephone interviews comprised 4 sections: questions regarding the types of ethical dilemmas faced at the physician's primary practice site; the strategies and resources used to address ethical dilemmas; the need for, use of, and satisfaction with ethics consultation services; and items regarding demographic data, education, practice characteristics, and experience with medical ethics (the questionnaire is available from the corresponding author on request).

Participation was voluntary. The study was reviewed and exempted from Institutional Review Board review by the Office of Human Subject Research at the National Institutes of Health.

Analysis

From the broader survey, the following open-ended questions were analyzed for this report:

- What was the situation that led to the most recent request [for an ethics consultation in which you participated]?
- Was there something specific that triggered the request for an ethics consultation? If yes, please specify.

Verbatim responses were analyzed with the use of a coding scheme that was developed by a consensus process. Investigators reviewed a 20% random sample of responses to identify major themes and to establish coding schemes for each of the 2 questions. The coding scheme developed for question 1 included general categories of ethical dilemmas and issues (table 1). The coding scheme developed for question 2 identified triggers that led physicians to request a consultation (table 2). Two investigators (G D and L S) separately coded the responses. Because the description of the trigger sometimes involved multiple elements, 2 codes were assigned to some responses. Three investigators (G D, L S, and M D) discussed coding disagreements until consensus was achieved. The coded data were then reviewed for completeness and consistency within the final categories.

After assigning codes to the open-ended responses, we analyzed the data with the use of simple descriptive statistics and calculated the frequency with which each response code appeared for each question.

The triggers listed in table 2 were sorted into 2 categories. Category 1 responses included those in which conflict or distress on the part of some party motivated the consultation request. Category 2 triggers included the remaining codes that were considered to involve process-oriented, more cognitively based, or introspective reasons for requesting a consultation. Univariate and multivariate logistic regressions were performed to determine which factors predict whether the request for an ethics consultation was triggered by conflict or distress (category 1) or by more introspective reasons (category 2). Only 1 responding physician gave a response that involved codes in both categories. This record was excluded from the analysis. Responses that indicated that a consultation was prompted by someone other than the physician or that the physician could not recall the situation and uninterpretable responses were excluded from analysis. A total of 177 physician responses, 93% of the total, were analyzed.

Table 1 *Recent ethical dilemmas that have led to ethics consultation requests*

Dilemma	Responses, no. (%)*
End-of-life issues (futility, withdrawal of life-sustaining treatment, etc)	154 (74.0)
Patient autonomy (decisions made on behalf of patient)	119 (57.2)
Conflict (between or among involved persons)	82 (39.4)
Other (includes genetics, abortion, substance abuse)	13 (6.3)
Religious and cultural issues	11 (5.3)
Professional conduct (questions about possible misconduct)	9 (4.3)
Truth telling and confidentiality	6 (3.0)
Justice issues (insurance, managed care, and fair access to health care)	2 (1.0)
Beneficence (the best way to promote the patient's welfare)	2 (1.0)

*Values add up to more than 100% because as many as 3 category codes were applied to responses. Responses of "don't know," "no" (5%), and uninterpretable (0.5%) were omitted from the table.

Table 2 *Factors that trigger ethics consultation requests*

Trigger	Responses, no. (%)*
Category 1	
Wants help resolving a conflict	66 (34.6)
Wants help in making a decision about planning care	25 (13.1)
Has emotional trigger	17 (8.9)
Category 2	
Wants help interacting with a difficult patient or family	19 (10.0)
Has regulatory, legal, or administrative reasons	15 (7.9)
Repeats previously described ethical problem	12 (6.3)
Wants help thinking through ethical issues	8 (4.2)
Someone else requested the ethics consultation	7 (3.7)
Wants assistance with communication	6 (3.1)
Has concern about the fairness of a decision process or procedural issue	4 (2.1)
Anticipates a bad situation	2 (1.1)

*Responses add up to more than 100% because 2 category codes were applied to some responses. Responses of "don't remember" (4.7%), uninterpretable (2.6%), and other explanations (2.6%) were omitted from the table.

RESULTS

Respondent characteristics

Of the 600 physicians selected from the master list, 537 met eligibility criteria. Of those, 344 (64%) completed an interview, and 76 (14%) actively refused. That left 117 (22%) who neither completed an interview nor actively refused by the end of the field period. About half of the

117 in the last group had been contacted on several occasions to provide opportunities for participation, and the other half could not be located. The distribution among the physicians completing the survey included 119 from the critical care or pulmonary care stratum, 130 from the fields of oncology and/or hematology, and 95 from the stratum of internists without a specified subspecialty.

Of the 344 responding physicians in the study, 190 reported requesting consultations. This group of 190 physicians was predominantly male (78.9%) and white (79.5%) (table 3). The primary religious affiliations were Protestant (32.3%) and Catholic (29.0%). Nearly 39% of respondents had attended a bioethics conference, and one fourth had been a member of a clinical ethics committee (not shown).

Physicians were predominantly in single or multispecialty groups, and most were in private practices (table 4). Half of the respondents practiced in densely populated communities (>500,000 people in a 20-mile radius), and half had an affiliation with a medical school.

Table 3 *Responding physician characteristics*

Characteristic	Sampled physicians, no. (%)*
Sex, n = 190	
Male	150 (78.9)
Female	40 (21.1)
Religion, n = 186	
Protestant	60 (32.3)
Catholic†	54 (29.0)
Jewish	27 (14.5)
Muslim	6 (3.2)
Hindu	10 (5.4)
Buddhist	2 (1.1)
No religious affiliation, atheist, agnostic	25 (13.4)
Other	2 (1.1)
Race, n = 190	
White	151 (79.5)
Nonwhite	39 (20.5)
Additional degrees held, n = 190	
Yes	36 (18.9)
No	154 (81.1)
Country of birth, n = 188	
United States	129 (68.6)
Other in North America, Australia, New Zealand	3 (1.6)
Central or South America, Caribbean	12 (6.4)
Europe	9 (4.8)
China or Taiwan	4 (2.1)
India, Pakistan, and Bangladesh	13 (6.9)
Other Asian or Pacific Rim	6 (3.2)
Africa	4 (2.1)
Middle East	8 (4.3)
Medical training outside United States, n = 189	
All	5 (2.6)
Part	43 (22.8)
None	141 (74.6)

*Not all categories add up to 100% because some physicians declined to answer the question.
†Includes Greek Orthodox.

Dilemmas that led to consultation requests

When asked about the most recent situation that had led to an ethics consultation (question 1), physicians most frequently reported dilemmas related to end-of-life care, patient autonomy, and conflicts between or among involved persons (table 1). Religious and cultural issues, issues of professional conduct, truth telling and confidentiality, justice issues (primarily about access to health care), and questions of beneficence in which physicians requested consultations to consider what was best for a patient were less commonly reported. Some physicians cited other dilemmas such as questions regarding abortion, genetic testing, and substance abuse. In all, 65% were assigned more than 1 code. For example when a physician described a situation involving a conflict about how to handle a patient's request for care at the end of life, this response was assigned 3 codes (end-of-life issues, patient autonomy, and conflict).

Triggers of consultation requests

We present samples of verbatim responses to illustrate the various types of triggers. Following are examples of category 1 responses—the more conflict-laden or emotionally charged triggers—reported in 57% of analyzed responses.

Resolving conflicts

About a third of responses were initiated to get help resolving a conflict. Many physicians described their frustration when conflicts led to ethics consultations: "[There was] an impasse between all of us . . . we couldn't agree. It came to a standoff." According to another respondent, "It had just gotten very difficult dealing with the family, and I naively thought that bringing in another party might help." Conflicts often arose when a patient was near the

Table 4 *Practice characteristics*

Practice	Sampled physicians, no. (%)*
Number of people within 20-mile radius, n = 187	
<50,000	10 (5.3)
50,000–100,000	28 (15.0)
100,000–250,000	33 (17.6)
250,000–500,000	23 (12.3)
>50,000	93 (49.7)
Practice type, n = 189	
Solo	13 (6.9)
Single or multiple specialty group	117 (61.9)
Academic, military, or general	47 (24.9)
Other	12 (6.3)
Medical school faculty, n = 190	
Yes	95 (50.0)
No	95 (50.0)
Percentage of patients covered by managed care, n = 166	
≤30%	94 (56.6)
>30%	72 (43.4)
Hospital public or private, n = 187	
Public	88 (47.1)
Private	99 (52.9)
For or not for profit, n = 184	
For profit	35 (19.0)
Not for profit	149 (81.0)
Teaching center with university, n = 189	
Yes	138 (73.0)
No	51 (27.0)
Number of beds, n = 189	
≤300	75 (39.7)
>300	114 (60.3)

*Each category has different total numbers because some physicians declined to answer some questions.

end of life and emotions were charged: "[The problem was] saying she was brain-dead with no hope and having the husband say, 'you're wrong'."

Interacting with a "difficult" patient or family member

Similarly, 10% of responses described a request for help with interaction with a difficult patient, family, or surrogate. One respondent observed, "The surrogate was unreasonable and not consistent with what the patient said." Another felt "there was indecision and squabbling among the family," and a third was frustrated with the "[a]ntagonism between the family and the operating surgeon."

Emotional trigger

Almost 9% of responses referred to an emotional trigger such as intimidation, fear, frustration, feeling at a loss about what to do, feeling uncomfortable about a situation, or encountering patient pain or suffering. A typical response began, "A man was in arrest on the ventilator. I went into the ICU and saw him on the machine. I thought this was cruel; we should not do this to the patient. I wanted to ignore the wife's wishes to do futile care. That was why we requested the consult." As with conflicts, emotional triggers also typically occurred around the end of life: "[It was my] overwhelming frustration with the excessive use of medical resources and the pain caused to the patient. [It was] a painful death instead of a dignified death."

The following are examples of category 2 responses—the more process-oriented, cognitively based, or introspective triggers—which made up 43% of analyzed responses.

Making a clinical decision or planning care

Of these, 13.1% of physicians requested a consultation when they needed to make a clinical decision or plan patient care: "Both the ethics consultation and legal consultation were used, and then the decision was whether you could legally and ethically take this patient's kidneys and use them in an operation." Another physician felt, "The patient's illness required [the] direction of a decision." In some responses, there was no available decision maker for the patient. "It was the fact that there was no immediate family member there—someone acting as power of attorney—and we felt we wanted someone else with that decision," and "The patient's HIV status was unknown to the family, and the patient was unable to make decisions."

Legal or regulatory reasons

Physicians had legal or regulatory reasons for requesting the consultation in 7.9% of responses. "There was a new member of the ethics team, and she knew a lot of the state laws and federal laws, and we wanted to talk to her." Fear of liability sometimes triggered a request: "A family member . . . said they would sue the hospital if life support was discontinued." Administrative or regulatory reasons were often involved: "They wanted to use nonapproved drugs."

Thinking through ethical issues

In 4.2% of responses, physicians needed help working through the ethical issues involved. One physician wanted

Table 5 *Results of univariate logistic regressions, using χ^2 test, on type of trigger response**

Term	A	B	Odds ratio†	Probability (*P*)
Sex	Male	Female	1.45	0.31
Years in practice‡	≥20	<10	1.00	1.00
Race	**White**	**Other**	**0.49**	**0.08**
Community size (within 20 miles)	**>500,000**	**≤500,000**	**0.55**	**0.06**
Additional degrees	Yes	No	0.88	0.75
Country of birth	United States	Other	1.30	0.41
Training in United States	**All of it**	**Not all of it**	**1.74**	**0.12**
Practice type	Solor or group practice	University, military, hospital, or resident	0.98	0.95
Medical school faculty	Yes	No	1.23	0.50
Percentage reimbursed from managed care	>30	≤30	1.30	0.43
Private or public hospital	Private	Public	0.93	0.82
Profit or not-for-profit	Profit	Not-for-profit	0.99	0.98
Teaching center affiliated	Yes	No	0.89	0.72
Patient beds	>300	≤300	1.23	0.52
Bioethics rounds attended	**≥6**	**≤5**	**0.57**	**0.09**
Attended bioethics conference	Yes	No	0.91	0.77
Ever member of bioethics committee	Yes	No	0.97	0.93
Ties with current members of ethics committee	Yes	No	1.00	1.00
Recent situation included end-of-life issues	Yes	No	0.92	0.83

*Moderately significant terms are in bold.
†Odds ratios of greater than 1.00 indicate that physicians in group A were more likely to request an ethics consultation for conflict or distress reasons.
‡Physicians in practice from 10 to 19 years were excluded from this analysis.

"[t]o clarify what is appropriate and what is not appropriate with the dying. I wanted someone from outside to discuss this with the family." Another was struggling with the "question whether it was ethical for a distant relative to make that decision."

Fostering communication

Less frequently cited reasons included a desire for assistance with communication (3.7%). One respondent related that, in requesting the consultation, "My goal was to increase the family members' understanding and acceptance of the patient's condition." Another expressed his "concern that [he] didn't understand all the dynamics between all the family members."

Fairness and justice

A few (2.1%) were concerned about the fairness of some decision or decision-making process, such as, "The patient

was being prevented from getting the care needed," or "Nursing staff were hearing things from the family—[they] didn't think the doctors were honoring what the patient wished."

Anticipation of a bad situation

Respondents called for consultations in 1.1% of responses because they expected a bad situation. One had "[a] feeling that it was going to be long term with no curative treatment."

Other responses

Other factors were cited by physicians in 2.6% of responses. In 6.3% of responses, the physician referred to the initial description of the ethical dilemma, without offering additional insight into the motivation for involving an ethicist. In a further 3.6% of responses, the physician indicated that someone else asked for the consultation.

Association between respondent characteristics and triggers

Univariate and multivariate analyses were used to determine what factors may be associated with a greater likelihood of requesting an ethics consultation triggered by conflict or other distressful situation. In the univariate analyses, no factors were significant at the 0.05 level (table 5). Moderately significant factors ($P<0.15$), including ethnicity of the physician (white vs minority; $P=0.08$), physicians who had all their training in the United States ($P=0.12$), community size (≤500,000 vs >500,000; $P=0.06$), and number of bioethics rounds attended (≤5 vs >5; $P=0.09$) were included in a multivariate logistic regression model.

The results of the multivariate model (table 6) were the following: white physicians were less likely than physicians of other race or ethnicity to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue (odds ratio [OR]=0.32, $P=0.02$). Physicians whose training took place solely in the United States were more likely to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue (OR=2.30, $P=0.04$). To a lesser degree, physicians working in a community where 500,000 people or less lived within a 20-mile radius of their main practice were less likely to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue (OR=0.57, $P=0.07$).

Table 6 *Results of multivariate logistic regression on type of trigger response (using terms significant in the univariate analyses)**

Term	A	B	Odds ratio†	Probability greater than *P*
Intercept				0.06
Race or ethnicity	**White**	**Other**	**0.32**	**0.02**
Community size (within 20 miles)	>500,000	≤500,000	0.57	0.07
Training in United States	**All of it**	**Not all of it**	**2.30**	**0.04**

*Significant terms are in bold.
†Odds ratios of greater than 1.00 indicate that physicians in group A were more likely to request an ethics consultation for conflict or distress reasons.

DISCUSSION

The triggers that prompt ethics consultations differ in most cases from a straightforward request for a description and analysis of the ethical issues at hand. The most common factors that triggered physicians' requests for ethics consultation were wanting help resolving a conflict; wanting assistance in interactions with a difficult family, patient, or surrogate; wanting help in making a decision or planning care; and emotional triggers. Physicians who are ethnically in the minority were more likely to ask for a consultation to deal with conflicts, and physicians who were trained in the United States and those from small communities were also moderately more inclined to call for consultations in response to emotionally charged situations.

Some limitations of the study must be recognized. The nature of the data collection, which involves self-report, precludes our ability to examine the relationship between self-reported and actual motivations in requesting ethics consultations. In addition, all respondents were physicians, qualified in internal medicine, and predominantly specialists in oncology and critical care. Other physicians and other health care practitioners were not included in this survey.

We describe factors that trigger clinicians to request ethics consultation; we have not judged their reasonableness. However, we note that some triggers, such as the need for legal advice, are often inappropriate because ethicists are typically not legal experts.

More than half the consultation requests were triggered by a need for help in responding to conflicts, difficult patients or families, or other emotionally charged situations. This finding suggests a shift in emphasis for ethics consultation from the way it has sometimes been conceived. La Puma and Schiedermayer suggested a decade ago that the ethics consultant requires the skills to identify and analyze ethical problems; use and model reasonable clinical judgment; communicate with and educate the clinical team, patient, and family; negotiate and facilitate negotiation; and teach and assist in problem resolution.[2] Similar descriptions of the skills required for ethics con-

sultation have been offered by other writers, including Fletcher and Siegler,[3] Moreno,[4] Andre,[5] and Arnold and Youngner in their *Core Competencies for Health Care Ethics Consultation.*[6] The data presented here confirm that, in general, these skills are, indeed, the ones that clinicians are requesting. However, although identifying and analyzing ethical dilemmas are important skills, there should also be a strong emphasis on the skills of conflict or even crisis resolution and on handling emotionally charged situations.

The data suggest further that in offering their skills, ethicists must be adept at identifying the particular needs of the clinician. The ethicist must do more than grasp the clinical situation and analyze it from an ethical standpoint. The factors that trigger a consultation request must be clearly identified so that they can be properly addressed. The consultant should help the clinician move beyond the precipitating concern to an analysis that helps the clinician learn from the situation and develop skills to address similar situations in the future. Although education has long been considered an important element of ethics consultation,[7] such teaching should also include proficiency in dealing with discord in clinical relationships.

Several authors have recently focused on the role of the ethicist as mediator. Walker has commended the shift toward this role as a positive philosophical shift "from thinking about morality as a theory applied to cases, to thinking about morality as a medium of progressive acknowledgment and adjustment among people in (or in search of) a common and habitable moral world."[8] This view is furthered by a growing contingent of ethicists who, drawing from the theories of Habermas, see consensus building not only as an intermediate service for physicians but also as a means to the end of building defensible moral theory.[9,10]

The frequency with which physicians report calling on ethics consultants to mediate conflict also points to the value of having ethicists involved at an early stage in particularly difficult medical situations. Early involvement might reduce conflicts and thus be helpful to patients, their families, and clinicians.[11] Because conflicts are difficult to resolve once they have developed, early communication may reduce their incidence.[12]

We note that conflicts were a more prevalent concern for minority physicians and physicians fully trained in the United States. We are cautious in asserting the validity of this finding because of the few minority physicians in the study. We can only speculate about possible reasons for the observation. Perhaps physicians in these groups either experience or perceive more conflicts. Physicians who represent minorities may experience more conflict-laden encounters with patients. Their patients may differ culturally from them, and they may have disagreements as a result of this. They and their patients may face greater disadvantages that lead to greater conflicts.

As health care organizations review existing services or look to establish ethics consultation services and hire or train ethics consultants, it is desirable for them to appreciate the motivations of clinicians who will seek these services.[13] Because physicians are prompted to seek consultation to resolve conflicts and defuse emotionally charged situations, the ethicist will often have the intricate task of mediating a conflict-laden situation while offering ethical analysis to shed light on the dilemmas at hand.

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